STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
11 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0011

ANGUS S. KING, JR.
GOVERNOR

KEVIN W. CONCANNON
COMMISSIONER

February 21, 2002

Michael Fiore
Director, Division of Integrated Health Systems
Family and Children's Health Programs Group
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Fiore:

The Maine Department of Human Services (DHS) is pleased to submit the attached Health Insurance Flexibility and Accountability (HIFA) waiver. The purpose of this waiver is to expand health care coverage to childless adults with incomes at or below 125% of the federal poverty level. Our waiver seeks expenditure authority to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

We are confident that you will find that this waiver application meets the goals of the HIFA initiative to the extent possible within the context of Maine's health care environment:

Serve individuals with income under 200% of poverty - Maine's waiver application seeks to serve the poorest unserved population in the State, childless adults with incomes under 125% of the federal poverty level. Maine expects to enroll 11,480 individuals under 100% of the federal poverty level in the waiver in the first year.

Provide statewide coverage with a benefit package that meets certain minimum criteria – Maine intends to allow this population to access the same benefit package that is available to current enrollees. On a statewide basis we propose to use the MaineCare (formerly Maine Medicaid) enrollment and service delivery system to provide access to health care coverage to this population. As you know, Maine successfully used this approach when it implemented its State Child Health Insurance Program (SCHIP) initiative in 1998.

Seek to develop coordinated private and public health insurance coverage – Within the context of the population to be served and Maine's rural environment, the State is seeking to maximize the use of private health insurance. Coordination with the private sector usually takes one of two forms, premium assistance and the use of private plans to provide or manage services. First, this very poor, often unemployed population rarely has access to private insurance. To the extent that such coverage is available, Maine will seek to maximize its use. Second, because of Maine's rural environment use of a private plan is not deemed feasible. Maine had a contract with a commercial managed care organization which was terminated by mutual agreement because of administrative and financial obstacles.

Use standardized data sources – Maine has primarily used CPS data to measure the State's uninsurance and coverage rates, and is using the medical inflation index for budget projections.

Include both Medicaid and SCHIP funds – This proposed waiver benefit only involves the use of Medicaid funds for the simple reason that, because of Maine's success in implementing our SCHIP initiative, our ongoing SCHIP funds are already allocated for the use of that population. Further, the State already provides coverage for children in families with income up to 200% of the federal poverty level.

The Maine Legislature has made it a policy priority to provide health care to this unserved population. The 120th Maine Legislature passed legislation requiring the Department to submit this waiver and allocating funds to support its implementation. Although we are confident that CMS will approve our HIFA application, in the event this does not occur, the Department of Human Services expects to submit the attached State Plan amendment to re-establish our community disproportionate share hospital (DSH) program for acute care hospitals as an alternative method of supporting some services for this population. This state plan amendment would revise acute care hospital DSH eligibility criteria to be what they were in 1995, so that all community hospitals would be eligible for a DSH allocation. Maine's proposed DSH program would compensate hospitals for bad debt and charity care. The majority of individuals who cause the hospitals to incur these costs would be eligible for MaineCare if this waiver were approved.

The attached chart outlines what expenditures under the proposed DSH program would have been in FFY 2000. It shows bad debt and charity care for all acute care Maine hospitals from a recent year. Bad debt and charity care represent a relatively constant 5% of gross patient service revenue. The money appropriated by the Maine Legislature to support the waiver would be used to fund this alternative service delivery mechanism. Obviously we would prefer not to pursue this option at all because it would be much less efficient than this HIFA waiver. It would result in overuse of emergency room services and other health care resources. Maine will achieve budget neutrality for this waiver by forfeiting the portion of our allocation that would have been used to fund the DSH program.

The Legislature directed the Department of Human Services to implement this coverage by October 2002. In order to ensure that we can begin coverage as soon as possible, we are hopeful that the waiver request will be found acceptable and approved expeditiously. We look forward to working with you to make coverage for very low income childless adults in Maine a reality.

Sincerely,

Kevin W. Concannon
Commissioner

cc: Theresa Sachs, Technical Director, Division of Integrated Health Systems
Moe Gagnon, SCHIP Project Officer, Division of State Children's Health Insurance
Ronald Preston, PhD., Associate Regional Administrator, Centers for Medicaid and State Operations
Irvin Rich, Health Insurance Specialist

Attachments:
Proposed State Plan Amendment
Hospital Bad Debt and Charity Care Chart
HIFA Template with Attachments B, C, D, E, F and G